UNIVERSITY of WISCONSIN
GREEN BAY

Master of Athletic Training

PHYSICAL EXAMINATION VERIFICATION

To be completed by student (*Please type or print)*

Last Name | First Name | Middle Initial

Student ID# | Date of birth (month, day, year)

Do you have any health problems or concerns that you would like to discuss today?

☐ Yes ☐ No

Student Signature | Date

To be completed by physician

A thorough history and physical examination were completed on the above named individual, with the following results:

☐ All findings were within normal limits

☐ Follow-up care is required; patient was advised

Comments:_____

Physician signature | Printed Name | Date

Facility name (please print) | Office phone number

Address